

Dr. Michael Jefferson
954-825-1004



CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize:

Dr. Jefferson and whomever he may designate as assistants to administer chiropractic care as deemed necessary to my _____ (indicate relationship of child),

(Name of Child)

Dated at _____

(City)

(State)

This _____ day of _____, 20_____

Signed: _____

(Parent or Guardian)

Witnessed: _____